Iowa Department of Human Services

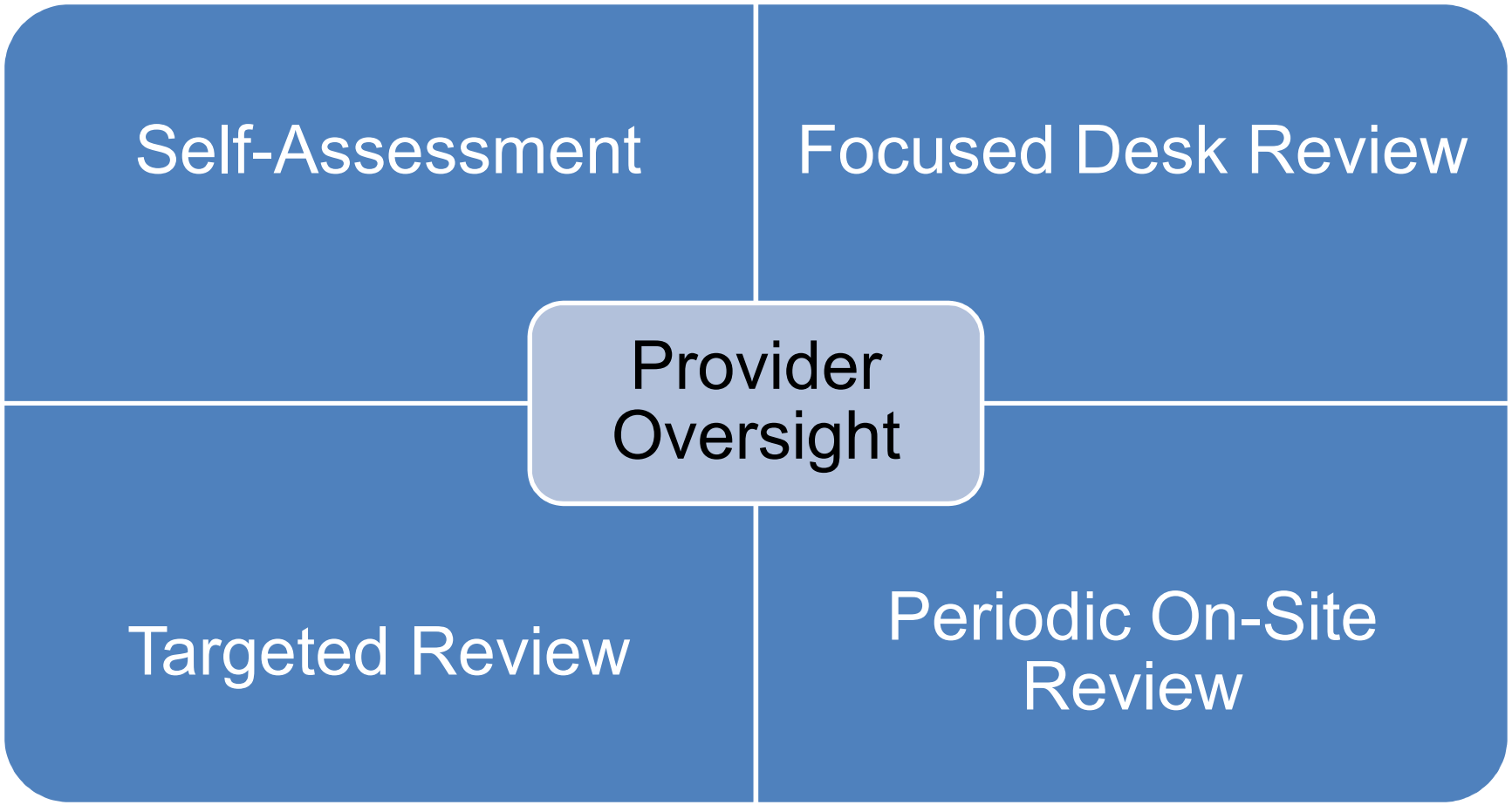
2014 Provider Quality Management Self-Assessment

October 2014

Objectives

- Overview of the Home and Community Based Services (HCBS) Provider Quality Oversight process
- Familiarize providers with the 2014 Self-Assessment
- Identify and address frequently asked questions
- Provide resources for technical support

Four Methods of Provider Oversight



Focused Review

- The purpose is to verify the provision of quality service delivery.
- Providers are randomly selected to represent a variety of services, provider types and geographical areas or if issues are identified through other quality improvement activities.
- Focused Review Topics change annually.
- Outcome could result in commendations, recommendations, corrective actions or an on-site review.

Targeted Review

- Can be conducted as needed, either announced or unannounced. May consist of a desk review or may be completed on site.
- Initiated as a result of concerns arising from other quality oversight activities including other types of reviews, incident reports, complaints, member surveys, or referral from other units within IME.
- Outcome could result in commendations, recommendations, corrective actions, or sanctions

Periodic/Certification On-Site Reviews

- Considered a “full” review.
- Evaluates evidence to support quality service delivery by examining evidence of compliance with the Code of Federal Regulations (CFR), Iowa Code, and Iowa Administrative Code (IAC) standards.
- Periodic review occurs on 5-year cycle, certification reviews are combined with periodic review when possible.
- Outcome could result in commendations, recommendations, corrective actions or sanctions.

Self-Assessment

- Annual self-reporting tool on standards for service delivery for identified HCBS Medicaid providers.
  - Covered services are identified in Section B of the self-assessment

- Providers are expected to self-report on CFR, Iowa Code, and IAC requirements for specific services and implementation of best practice recommendations and develop corrective action plans as needed.

Self-Assessment (continued)

- Part of demonstrating your on-going internal quality improvement process.
- Opportunity to self-govern and assess outcome of future reviews.

Due Date

- By December 1, 2014
- **Incomplete self-assessments will not be accepted.**
- If any portion of the self-assessment is not completed as instructed, the provider will be notified and a completed self-assessment shall be resubmitted by the provider by December 1, 2014.
- **Failure to submit the required 2014 Quality Management Self-Assessment by December 1, 2014 will jeopardize your agency's Medicaid enrollment.**

New for 2014

- Centers for Medicare and Medicaid Services (CMS) Final Rule 42 CFR 441.301(c)(4) and 42 CFR 441.710(a)
  - Defines setting requirements
  - Maximizes access to community living and services in the most integrated setting
- Iowa's HCBS Transition Plan
  - Impacts all HCBS quality assurance activities, including the self-assessment.
- Person-Centered Service Plan 42 CFR 441.725.
  - Effective January 2014

New for 2014 (continued)

- 2014 Self-Assessment gathers additional information regarding **service settings** and **service plans.**

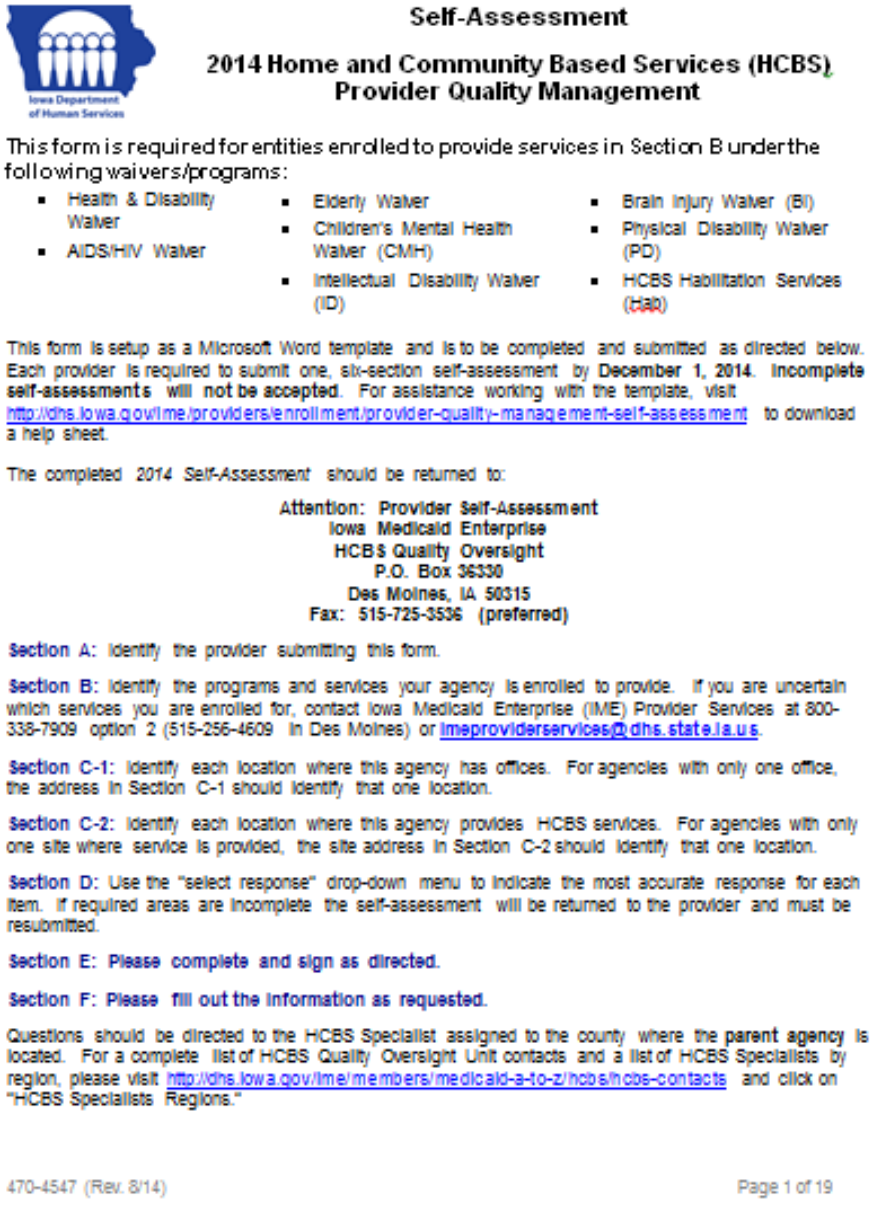
- HCBS quality assurance activities are designed to give providers the opportunity to demonstrate evidence of compliance with the final rule and receive technical assistance as needed.

- If your agency has not fully implemented changes and is unable to provide evidence to demonstrate compliance, respond appropriately on the self-assessment and include corrective action plans as required.

The 2014 Self-Assessment

- http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment

- Save form to your computer
- Complete electronically
- Read instructions carefully



Self-Assessment

2014 Home and Community Based Services (HCBS) Provider Quality Management

This form is required for entities enrolled to provide services in Section B under the following waivers/programs:

- Health & Disability Waiver
- AIDS/HIV Waiver
- Elderly Waiver
- Children's Mental Health Waiver (CMH)
- Intellectual Disability Waiver (ID)
- Brain Injury Waiver (BI)
- Physical Disability Waiver (PD)
- HCBS Habilitation Services (Hab)

This form is setup as a Microsoft Word template and is to be completed and submitted as directed below. Each provider is required to submit one, six-section self-assessment by **December 1, 2014**. **Incomplete self-assessments will not be accepted**. For assistance working with the template, visit http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment to download a help sheet.

The completed *2014 Self-Assessment* should be returned to:

Attention: Provider Self-Assessment
Iowa Medicaid Enterprise
HCBS Quality Oversight
P.O. Box 36330
Des Moines, IA 50315
Fax: 515-725-3536 (preferred)

Section A: Identify the provider submitting this form.

Section B: Identify the programs and services your agency is enrolled to provide. If you are uncertain which services you are enrolled for, contact Iowa Medicaid Enterprise (IME) Provider Services at 800-338-7909 option 2 (515-256-4609 in Des Moines) or imeproviderservices@dhs.state.ia.us.

Section C-1: Identify each location where this agency has offices. For agencies with only one office, the address in Section C-1 should identify that one location.

Section C-2: Identify each location where this agency provides HCBS services. For agencies with only one site where service is provided, the site address in Section C-2 should identify that one location.

Section D: Use the "select response" drop-down menu to indicate the most accurate response for each item. If required areas are incomplete the self-assessment will be returned to the provider and must be resubmitted.

Section E: Please complete and sign as directed.

Section F: Please fill out the information as requested.

Questions should be directed to the HCBS Specialist assigned to the county where the **parent agency** is located. For a complete list of HCBS Quality Oversight Unit contacts and a list of HCBS Specialists by region, please visit http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/hcbs-contacts and click on "HCBS Specialists Regions."

Section A – Provider Identification

Please identify your agency by providing the following information (please type using the text entry fields below).

Employer ID number (EIN) (9-digits):					
Provider name (as registered to EIN indicated above):					
Administrator/CEO:			Title:		
Mailing address:			Agency address:		
City:	State:	Zip:	City:	State:	Zip:
County:			County:		
Name of person responsible for agency quality improvement activities:			Phone number: Ext:		
Title of person responsible for agency quality improvement activities:			Fax number:		
Quality coordinator's email address:			Administrator's email address:		
Agency website address:					

Section A – Provider Identification (continued)

- Demographic Information
- EIN = employer ID# or taxpayer ID#
- Legal name, if different from name you are doing business as(DBA)
- Correct email addresses
- If you have had a change in legal name or address, complete form 470-4608 on http://dhs.iowa.gov/ime/providers/forms

Section B – Service Enrollment

Indicate *each* of the programs and corresponding services your agency is **enrolled** to provide (regardless of whether or not these services are currently being provided). If your agency is not enrolled for any of the services in this section, you are not required to submit the *2014 Provider Quality Management Self-Assessment*. If you are uncertain as to the services your agency is enrolled for, please contact the IME Provider Services as explained on page one.

Program	☐ AIDS/HIV Waiver	☐ BI Waiver	☐ CMH Waiver
Services	☐ Adult Day Services ☐ Agency Consumer-Directed Attendant Care (CDAC) ☐ Counseling ☐ Respite	☐ Adult Day Services ☐ Behavior Programming ☐ Agency Consumer-Directed Attendant Care (CDAC) ☐ Family Counseling and Training ☐ Interim Medical Monitoring and Treatment (IMMT) ☐ Pre-Vocational Services ☐ Respite ☐ Supported Community Living (SCL) ☐ Supported Employment (SE)	☐ Family and Community Support Services ☐ In-Home Family Therapy ☐ Respite

Section B – Service Enrollment (continued)

- Select ALL services you are enrolled for.
- You may be enrolled for additional HCBS services not listed in Section B. These services are not part of the self-assessment or HCBS quality oversight process.
- Self-Assessment answers will be based on policies and procedures for the services indicated in Section B.

Section C-1 –Office Locations

INSTRUCTIONS Identify each location from which your agency provides oversight of HCBS services. For agencies with only one office, details for "Location #1" (below) MUST be provided. Include additional copies of this page as needed.

■ **Location # 1**

NPI number(s) (10-digits):					
Provider/Agency name(Name doing business as):					
Contact person:			Phone number:		Fax number:
Title of contact person:			Email address:		
Mailing address:			Agency address:		
City:	State:	Zip:	City:	State:	Zip:
Office Hours:	Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:				

■ **Location # ___**

NPI number(s) (10-digits):					
Provider/Agency name(Name doing business as):					
Contact person:			Phone number:		Fax number:
Title of contact person:			Email address:		
Mailing address:			Agency address:		
City:	State:	Zip:	City:	State:	Zip:
Office Hours:	Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:				

Section C-1 - Office Locations (continued)

- Include all agency office locations, including satellite offices.
  - List all NPIs related to each office location.
- Can print additional pages as necessary for all office locations.
- Do not include 24-hour residential sites as a location unless an agency office is located at that site.

Section C-2 – Site Locations

New for 2014

- Part of Iowa's transition plan submitted to CMS to gather information on current HCBS service locations

- A setting is considered provider-owned or controlled when it is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS.

- Applies to all services identified in Section B, **except** Respite.

Section C-2 – Site Locations Examples:

Provider owned/controlled site may be:

-buildings owned or leased by the provider agency

-have staff present for 24-hour care

-nursing facility or intermediate care facility (ICF)

Member owned/controlled site may be:

-owned by member

-leased by member from someone not affiliated with the provider agency

-owned by member's legal guardian

Section C-2 –Site Locations

INSTRUCTIONS: Identify each location where your agency is providing HCBS services. For agencies with only one site, details for "Site #1" (below) MUST be provided. Provider owned, provider controlled, member owned and member controlled categories are clarified in the HCBS Settings Transition Exploratory Questions located on the IME website http://dhs.iowa.gov/ime/about/initiatives/HCBS. Include additional copies of this page as needed.

■ **Site #** ___

NPI number (10-digits):			Site name:
Provider/Agency name (Name doing business as):			
Contact person:		Phone number:	Fax number:
Title of contact person:			Email address:
Site address:			Provider owned / Provider controlled: ☐ Member owned / Member controlled: ☐
City:	State:	Zip:	Type of residence (house, apartment, duplex etc.):
Total number of members living at this site:			For sites with five or more members, is the site licensed by the Department of Inspections and Appeals or otherwise approved by the Department of Human Services: Select Response

Section D – Iowa Administrative Code Standards

II. Providers are required to meet the following training requirements	
Within 30 days of employment for full-time staff (unless otherwise indicated), the following training requirements must be met and documented for all staff providing services. Part-time staff must have these trainings documented and completed within 90 days of employment (unless otherwise indicated). Trainings are required for certain habilitation and waiver programs as listed below. It is recommended as a best practice that each waiver program provide all the trainings listed below.	**Response Options:**
1. The curriculum used by the provider is approved by the Iowa Department of Public Health, and includes the following: **IAC 641-93.1**	
a. Child and/or Dependent Abuse training completed within six months of hire (or documentation of current status) **Iowa Code 235B.16 / 232.69**	☐ YES ☐ NO
b. Training every five years **Iowa Code 235B.16 / 232.69**	☐ YES ☐ NO
2. Member rights **IAC 77.37(1)"e" / 77.39(1)"e"**	☐ YES ☐ NO ☐ N/A
3. Rights restrictions and limitations **IAC for Hab, BI and ID 77.25(4) / 77.37(1)"e" / 77.39(1)"e"**	☐ YES ☐ NO ☐ N/A
4. Member confidentiality	☐ YES ☐ NO

Section D – Iowa Administrative Code Standards (continued)

- You must select a response for each standard. Any self-assessments with unanswered standards or comments will be returned and considered not complete.
  - If indicating “Yes”, it means you have a policy and/or evidence in place as required. It is not necessary to explain your response.
  - If indicating “No”, you must describe a corrective action plan (CAP) to meet the standards
  - If indicating “NA”, you must describe why the standard(s) are not applicable to your facility.

Section D – III. Requirement C Service plans required for all providers

New for 2014

- Applies to providers of all HCBS services covered by the self-assessment
  - 1. G - K applies to HCBS services in provider-owned, provider-controlled settings

- Compliance may be evidenced in the provider or case management service plan, or other documents.

Requirement C: Service plans required for all providers	
***At a minimum*, there will be evidence of:**	**Response Options:**
1. **All providers** at a minimum, the service plan will identify: **42 CFR 441.301(c)(4) and 42 CFR 441.710(a)**	
a. The setting is integrated in, and facilitates the individual's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like individuals without disabilities	Select Response:
b. The setting is selected by the individual among all available alternatives and identified in the person-centered service plan	Select Response:
c. An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected	Select Response:
d. Individual initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented	Select Response:
e. Individual choice regarding services and supports, and who provides them, is facilitated	Select Response:
f. Any rights restriction (for example to address the safety needs of an individual with dementia) must be time limited, contain member's informed consent, supported by a specific assessed need and documented in the person-centered service plan	Select Response:
g. In a provider owned or provider controlled setting, each individual has privacy in their sleeping or living unit	Select Response:
h. In a provider owned or provider controlled setting, individuals sharing units have a choice of roommates in that setting	Select Response:
i. In a provider owned or provider controlled setting, individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	Select Response:
j. In a provider owned or provider controlled setting, individuals are able to have visitors of their choosing at any time	Select Response:
k. In a provider owned or provider controlled setting, the setting is physically accessible to the individual	Select Response:

2. **All providers** at a minimum, the service plan will identify: **42 CFR 441.725**	
a. The service plan is based on the current assessment	Select Response:
b. The service plan identifies observable or measurable individual goals and action steps to meet the goals	Select Response:
c. The service plan includes interventions and supports needed to meet those goals with incremental action steps, as appropriate	Select Response:
d. The service plan includes staff, people, or organizations responsible for carrying out the interventions or supports	Select Response:
e. Services defined in the service plan are appropriate to the severity level of problems and specific needs or disabilities	Select Response:
f. The plan reflects desired individual outcomes	Select Response:
g. Activities identified in the service plan encourage the ability and right of the individual using the service to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process	Select Response:
h. Staff monitors the service plan with review occurring regularly. At least annually, staff assess and revise the service plan to determine achievement, continued need, or change in goals or intervention methods. The review includes the individual using the service, with the involvement of significant others as appropriate.	Select Response:
i. Staff develops a separate, individualized, anticipated discharge plan as part of the service plan that is specific to each service the individual receives	Select Response:
j. The service plan includes documentation of any rights restrictions, why there is a need for the restriction and a plan to restore those rights or a reason why a plan is not necessary or appropriate	Select Response:

3. Habilitation providers: IAC 78.27(4) The service plan shall set out service goals and activities:	
a. The goals are personal, as identified by the member and the consumer's interdisciplinary team	Select Response:
b. The goals and/or objectives are measurable and time limited	Select Response:
c. The goal action steps are specific, provide specific direction to staff implementing the goal, and identify the specific person(s) responsible for completing each step	Select Response:
d. The supports to be provided to the member	Select Response:

- Habilitation providers also need to address service plan requirements from Chapter 78.

Section D – III. Requirement I Contracts with members

New for 2014

- Requirements #1-3 give the provider the opportunity to examine whether they are meeting CFR final rule in regards to provider-owned or operated sites.

- Requirements #4 and #5 are only required per Chapter 77.37(3) for ID Supported Employment and SCL providers (excludes RBSCL).

Section D – III. Requirement I Contracts with members (continued)

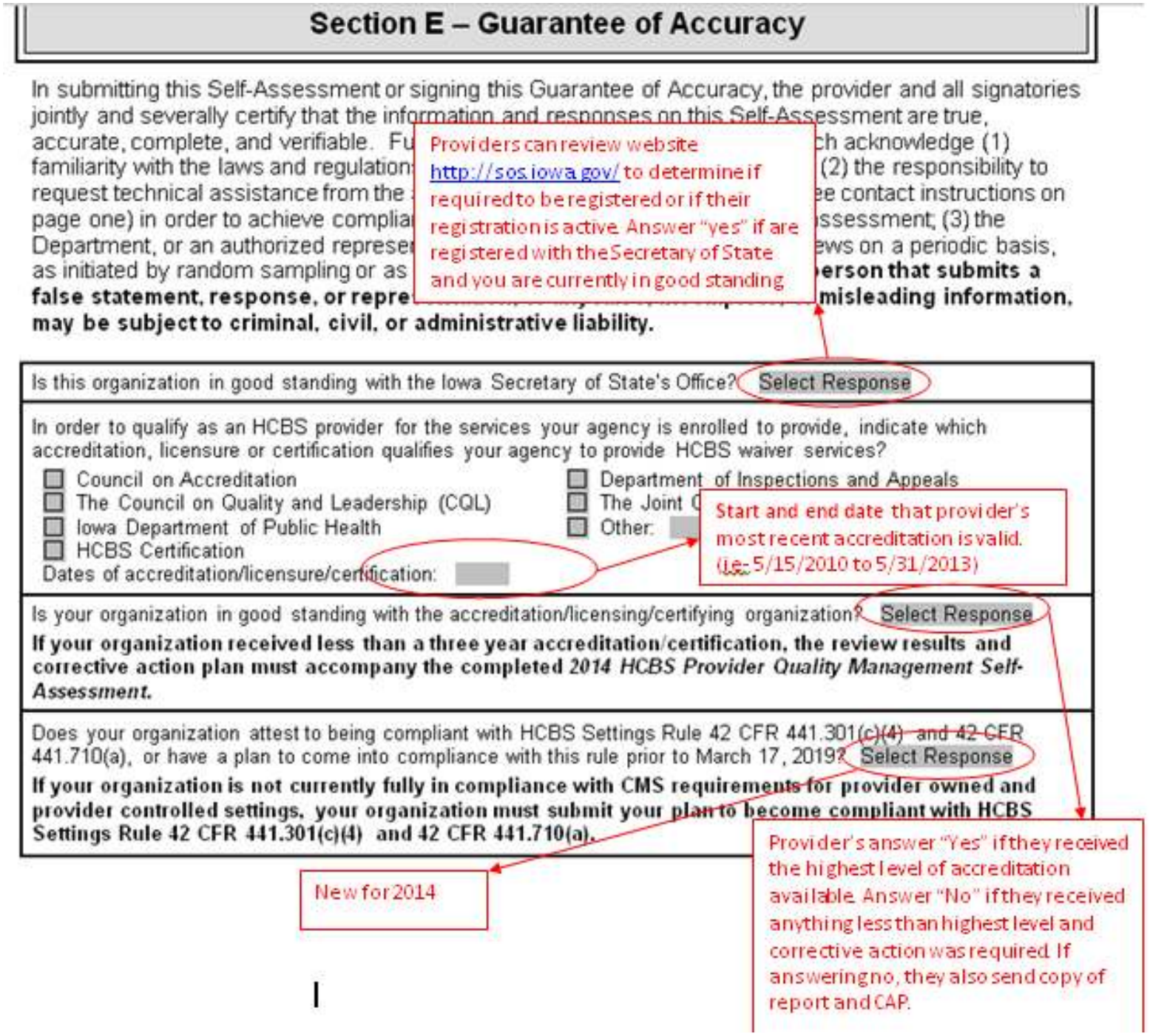
Requirement I: Contracts with members **IAC 77.37(3), CFR 2249-F and 2296-F**	
At a minimum, the agency shall have written procedures which provide for the establishment of an agreement between the member and the provider and evidence will be supplied that:	**Response Options:**
1) Provider owned or provider controlled home is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the State, county, city, or other designated entity	Select Response:
2) Provider owned or provider controlled home has entrance doors lockable by the individual, with only appropriate staff having keys to doors	Select Response:
3) In a provider owned or provider controlled home individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement	Select Response:
4) The agreement shall define the responsibilities of the provider and the member, the rights of the member, the services to be provided to the member by the provider, all room and board and co-pay fees to be charged to the member and the sources of payment (IAC 77.37(3))	Select Response:
5) Contracts shall be reviewed at least annually (IAC 77.37(3))	Select Response:
If indicating "No," describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
If indicating "NA," you must describe why the standard(s) are not applicable to your facility:	

Section D -
IV. Quality Improvement Plan

- Provides guidance on how to design and implement a Quality Improvement Plan (QIP).

- Reflects best practices in QIP development and implementation.
  - Written QI Plan
  - Discovery, Remediation, and Improvement activities

- Allows providers to self-identify and correct areas of need.


Section E – Guarantee of Accuracy
In submitting this Self-Assessment or signing this Guarantee of Accuracy, the provider and all signatories jointly and severally certify that the information and responses on this Self-Assessment are true, accurate, complete, and verifiable. Fu ch acknowledge (1) familiarity with the laws and regulation (2) the responsibility to request technical assistance from the ee contact instructions on page one) in order to achieve compli ssessment; (3) the Department, or an authorized repres ews on a periodic basis, as initiated by random sampling or as erson that submits a false statement, response, or repre misleading information, may be subject to criminal, civil, or administrative liability.
Providers can review website http://sos.iowa.gov/ to determine if required to be registered or if their registration is active. Answer "yes" if are registered with the Secretary of State and you are currently in good standing
Is this organization in good standing with the Iowa Secretary of State's Office? Select Response
In order to qualify as an HCBS provider for the services your agency is enrolled to provide, indicate which accreditation, licensure or certification qualifies your agency to provide HCBS waiver services?
Council on Accreditation
The Council on Quality and Leadership (CQL)
Iowa Department of Public Health
HCBS Certification
Department of Inspections and Appeals
The Joint C
Other:
Dates of accreditation/licensure/certification:
Start and end date that provider's most recent accreditation is valid. (i.e. 5/15/2010 to 5/31/2013)
Is your organization in good standing with the accreditation/licensing/certifying organization? Select Response
If your organization received less than a three year accreditation/certification, the review results and corrective action plan must accompany the completed 2014 HCBS Provider Quality Management Self-Assessment.
Does your organization attest to being compliant with HCBS Settings Rule 42 CFR 441.301(c)(4) and 42 CFR 441.710(a), or have a plan to come into compliance with this rule prior to March 17, 2019? Select Response
If your organization is not currently fully in compliance with CMS requirements for provider owned and provider controlled settings, your organization must submit your plan to become compliant with HCBS Settings Rule 42 CFR 441.301(c)(4) and 42 CFR 441.710(a).
New for 2014
Provider's answer "Yes" if they received the highest level of accreditation available. Answer "No" if they received anything less than highest level and corrective action was required. If answering no, they also send copy of report and CAP.

Section E – Guarantee of Accuracy (continued)

- Accreditation/Licensing/Certification needed to provide enrolled HCBS services
  - Identify the organization(s) from the list provided
  - Include start and end dates of accreditation/licensure/certification
  - Accreditation review results and corrective action plan must be included if less than a 3 year accreditation

Section E – Guarantee of Accuracy (continued)

- Signatures ensure the information is accurate, complete, and verifiable
  - Self-Assessments without signatures will be returned
  - Factor in time to obtain signatures
  - Indicate if your agency does not have a board of directors

Iowa Department of Human Services

2014 Provider Quality Management Self-Assessment

Section F – Direct Support Professional Workforce Data Collection

Direct Support Professional Workforce Data Collection

Provider Name_____

NPI Provider Number(s)_____

(Complete only one form and list all NPI Numbers)

Instructions

For the purposes of these questions, a direct support professional is an individual who provides supportive services and care to people who are elderly, experiencing illnesses, or disabilities. This definition *excludes* individuals working as nurses, social workers, counselors, and case managers.

Individuals providing the following waiver services should be considered direct support professional workers:

- Adult Day Services
- Behavioral Programming
- CCO
- CDAC
- Family and Community Support Services
- Home Health
- Homemaker
- Interim Medical Monitoring and Treatment
- Prevocational Services
- Respite
- Residential SCL
- SCL
- Supported Employment

1. Please list your organization's total number of full-time and part-time employees (including contract employees).

   _____ Total Number of Full-time and Part-time Employees

   Of this total, please list the number of full-time and part-time employees providing direct support services according to the definition provided above. Please include supervisors and coordinators who provide direct support services.

   _____ Number of Full-time Direct Care Workers (including contract employees)

   _____ Number of Part-time Direct Care Workers (including contract employees)

2. The U.S. Department of Labor utilizes the following three titles and definitions to gather information on the direct support professional workforce.

Please list the number of individuals you employ in the following three categories. Choose the category that best reflects services provided. Individuals do not need to be certified as a home health aide or nurse aide to be included in those categories. An individual cannot be counted in more than one category.

Personal and Home Care Aides

Often called direct support professionals, these workers provide support services such as implementing a behavior plan, teaching self-care skills and providing employment support, as well as providing a range of other personal assistance services. They provide support to people in their homes, residential facilities, or in day programs, and are supervised by a nurse, social worker, or other non-medical manager.

_____ Number of Personal and Home Care Aides (including contract employees)

Home Health Aides

Home health aides typically work for home health or hospice agencies and work under the direct supervision of a medical professional. These aides provide support to people in their homes, residential facilities, or in day programs. They help with light housekeeping, shopping, cooking, bathing, dressing, and grooming, and may provide some basic health-related services such as checking pulse rate, temperature, and respiration rate.

_____ Number of Home Health Aides (including contract employees)

Nursing Aides

Most Nursing Aides have received specific training for the job and some have received their certification as a Certified Nursing Assistant (CNA) in Iowa. According to the Department of Labor, Nursing Aides provide hands-on care under the supervision of nursing and medical staff in hospitals and nursing care facilities, although they do work in home and community based settings as well. Nursing Aides often help individuals eat, dress, and bathe, and may take temperature, pulse rate, respiration, or blood pressure, as well as observing and recording individuals' physical, mental, and emotional conditions.

_____ Number of Nursing Aides (including contract employees)

Timeliness

- Due by December 1, 2014
- Implementation of corrective action to address current CFR, Iowa Code, and IAC standards must be completed within 30 days of the date in Section E.
- For any areas relating to CFR 2249 and 2296, corrective action must identify how providers will come into compliance on or before March 17, 2019.

- **Failure to submit the required 2014 Quality Management Self-Assessment will jeopardize your agency's Medicaid enrollment.**

Submission

- Self-Assessment will be submitted as one complete document
- Fax or Mail only
  - Fax preferred
- Include supporting documentation from accreditation, only if needed (See Section E – Guarantee of Accuracy)

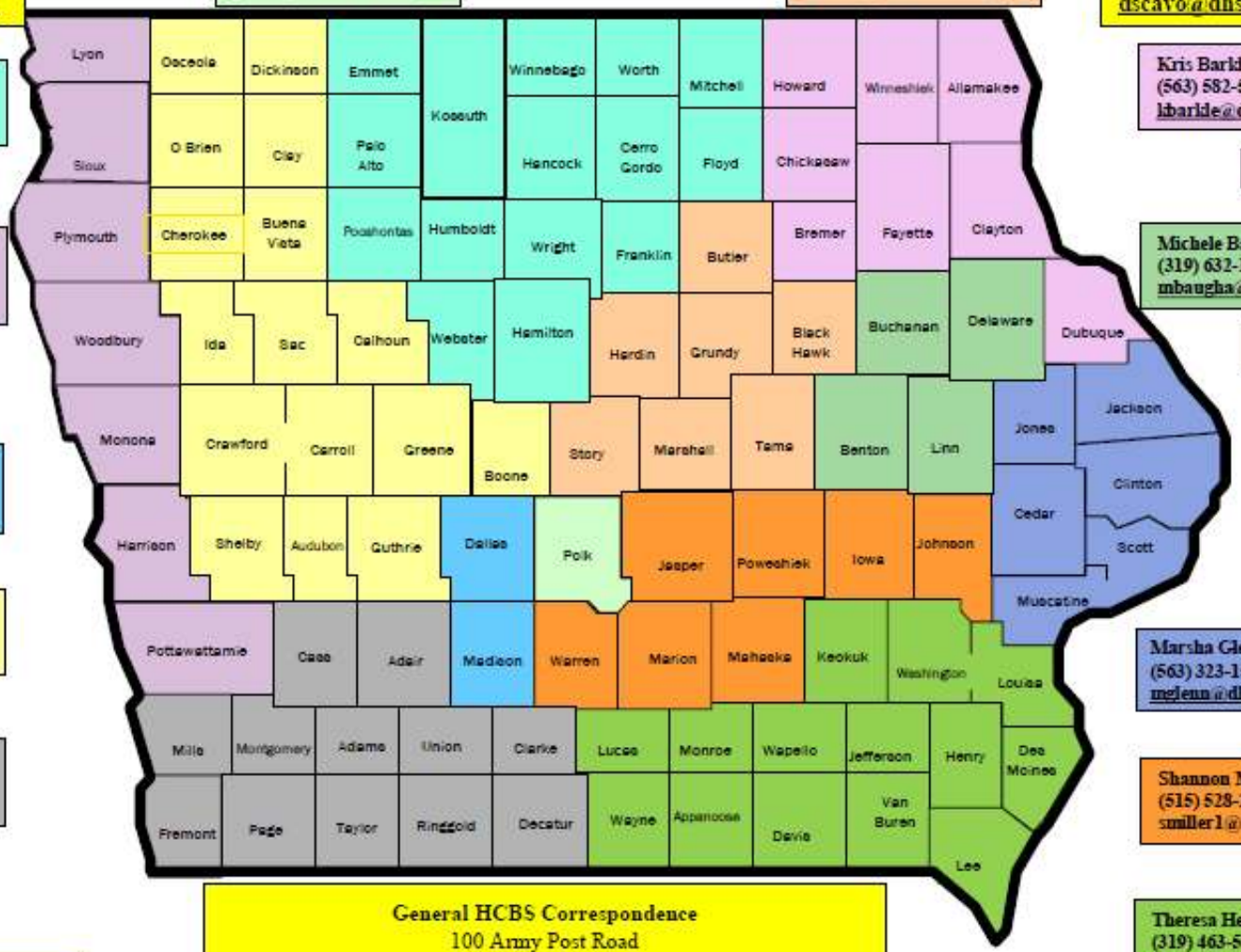
What to expect following submission

- Providers will receive confirmation of receipt by IME
- Incomplete submission
  - If areas are incomplete or corrective action was not identified, the provider will be notified and the self-assessment must be resubmitted.
  - The December 1, 2014 due date still remains.

HCBS Support

- Where to find more information/support
  - Website http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment
    - Self-Assessment Form
    - Link to regional specialist map
    - Frequently Asked Questions (FAQs)
    - Self-Assessment Training slides
  - Informational Letter No.1430

HCBS SPECIALIST OVERSIGHT REGIONS



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Shannon Miller
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Nebraska

Theresa Hemann
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themann@dhs.state.ia.us

Incident and Complaint Specialists
Shelia Leonard (515) 974-3038
sleonar@dhs.state.ia.us

Stephanie Jones (515)-256-4654
sjones@dhs.state.ia.us

General HCBS Correspondence
100 Army Post Road
P.O. Box 36330
Des Moines, Iowa 50315
Fax: 515-725-3536
waiverslot@dhs.state.ia.us : Waiver wait list/slot questions
hcbsir@dhs.state.ia.us : Complaints and Incident report follow-up
hcbswaivers@dhs.state.ia.us : General HCBS questions

Revised 7.28.14

Additional Resources

- Centers For Medicare and Medicaid Services
  http://www.cms.gov/

- Iowa Code and Iowa Administrative Code (IAC):
  http://search.legis.state.ia.us/nxt/gateway.dll/ic?f=templates&fn=default.htm

- HCBS Settings Transition
  http://dhs.iowa.gov/ime/about/initiatives/HCBS

Additional Resources (cont.)

- Informational Letter sign-up on IMPA homepage: https://secureapp.dhs.state.ia.us/impa

- Archived Informational Letters http://dhs.iowa.gov/ime/providers/rulesandpolicies/bulletins

- Provider Services:

  http://dhs.iowa.gov/ime/providers

  imeproviderservices@dhs.state.ia.us

  1-800-338-7909 (toll free) or 515-256-4609 (Des Moines)

  Select Option 4

- Send questions to:

hcbsqi@dhs.state.ia.us

Subject: 2014 Self-Assessment